2008 Semi-Annual Progress Report for Michigan

January 1-June 30, 2008, Semi-annual Progress Report

Grantee: Michigan Program Component: Program Planning and Evaluation

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
1.1 For five years, document progress to meaningfully engage American Indian tribal health centers in immunization activities.	Partially Met/Ongoing	Contacted all tribal health centers & compiled updated lists of tribal names as well as commonly used names of sites. She also maintains an accurate list of current contact information for centers & their sites. MDCH coordinated immunization program planning and implementation with tribal/638 health clinics, the Indian Health Service, and other entities that provide medical services to this population. This may include the sharing of resources including AFIX, INE, VFC enrollment, MCIR usage, and technical assistance.
1.2 For a five-year period, MDCH Division of Immunization will actively engage in self-evaluation & strategic planning to ensure the program is guided in making changes to more effectively carry out the mission of achieving & sustaining high immunization rates & maximizing programmatic outcomes.	Met	The Core Strategic planning team meets quarterly. An evaluation plan using Adolescent AFIX has been identified and chosen for further work over the next 5 years. Other ongoing evaluation: conference evaluations available from adolescent conference in June 2008, all regional conferences, IAP meetings, travel vaccine and community vaccinator's forum

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1.3 Review and update the MDCH Pandemic Influenza Plan annually.	Partially Met	An updated version (3.5) of the MDCH Pandemic Influenza Plan was approved July 2008. MDCH staff are increasing familiarity and confidence in seasonal flu vaccine and enhancing levels of seasonal influenza vaccine among target groups - met Pandemic Influenza exercise is scheduled for September 2008; MDCH participated in the CDC Pandemic Influenza Doses Administered Pilot Reporting Event (PIDAPRE; (see Appendix A)) in November 2007. MDCH is required to do two transmissions of data for two clinic sessions at a minimum. CDC allowed Michigan to pull statewide data which helped evaluate volume. The exercise was conducted November 6, 2007 and November 13, 2008 In addition, MDCH will be participating in the 2008 Vaccine Doses Administered Exercise sometime between October and December. This will be more extensive than the 2007 exercise. It requires more clinics and at least one of them needs to be in a City Readiness Initiative area. CDC at this point has indicated that MDCH will be able to do a statewide pull of data. This test file will be sent to CDC by August 29th and by September 12th we will confirm the 4 week period in which we will participate.

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1.3a Assist pandemic flu coordinators on Pandemic Influenza Coordinating Committee (PICC) projects.	Partially Met	Assist in the development of educational materials, posters, toolkits, and resources, including: a) Pandemic Planning Workbook & Online Toolkit for Educators - disseminate to all K-12 superintendents in the State of Michigan in October of 2007; update workbook on an as needed basis; b) Hand Hygiene Measures for Department of Transportation – met; distributed to all MDOT employees; will be distributed again for the 2008-09 flu season to all State Of Michigan employees and partner organizations through the PICC – much wider distribution channel for future mailing c) Educational PowerPoint & Fact Sheets for K-12 Administrators d) Safe Work Practices All-Hazards Planning Template for State Departments; Assist pandemic flu coordinators in providing guidance to State of Michigan Departments on pandemic planning efforts, developing pandemic plans, etc. – in progress; draft is being vetted up through MDCH and OSE; soliciting feedback from Dept Health and Safety Coordinators before sending on to all State Depts e) Maintain membership on PICC workgroups, including School/Public Health; Safe Work Practices; Law Enforcement & EMS; Border/Transportation as well as membership on PICC Human Health Subcommittee. f) Identify issues & resolve matters specific to each PICC workgroup g) Develop white papers on issues that need to be addressed; communicate white paper findings to relevant state departments; report white –was partially met; Eden Wells gave PICC presentation to cabinet recently but don't know if white papers were created

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1.4 By December 31, 2009, develop a workforce capacity strategic planning group to assist in crisis planning & cross training.	Partially Met	The core strategic planning committee has maintained quarterly meetings and tasked one subcommittee with surge capacity and cross training. The first staff cross training activity occurred at the July 2008 Division staff meeting. A staff survey / capacity was analyzed by the Surge Capacity and Cross Training strategic planning subcommittee.
1.5 By December 31, 2008, assist with planning MI College & University Pandemic Planning Webinar. .	Met	Developed Webinar Planning Subcommittee – represented by MDCH; large & small, residential & non-residential, lower & upper peninsula colleges & universities in MI; Created a survey to determine level of interest and topics to be discussed at upcoming webinar/summit; Determined format for the event → live webinar Held live Webinar in November 2007 with the target audience of pandemic planners at colleges and universities Topics included: principles of pandemic planning, academic affairs, student services, operational issues, and human resource issues; Reached 350 participants at 35 institutions; positive evaluations; numerous questions generated and asked during and after the Webinar; Webinar available online for up to one year

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Grantee: Michigan Program Component: Vaccine Accountability and Management

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
2.1 By December 31, 2008, submit to CDC an updated Fraud & Abuse policy based on additional guidance from CDC & CMS.	Met	Completely revised Fraud & Abuse policy. CMS & AG's office were involved in revision. Sent CDC new version 12/07. Established Fraud & Abuse Hotline @ 1-517-335-8159. This line is answered by MDCH staff during business hours. VFC staff presented new policy at the fall IAP statewide meetings in 2008. Examples were discussed.
2.1a Annually through December 31, 2012, review, update & implement new accountability policies & fraud & abuse policies based on program experience & updated CDC guidance & requirements.	Partially Met	Identified 3 MDCH staff as key decision makers regarding Fraud & Abuse and submitted those names to CDC 12/2007. Consequences of Fraud & Abuse were identified & distributed at the fall IAP meeting. VFC staff maintains a Fraud & Abuse Hotline. An Accountability Workgroup was created at MDCH, have met several times to review policy & update as needed. New policy is in draft for vaccine losses, wastage & replacements. Registry based MCIR "Discoverer" reports are run for internal audits & situations to rule out or confirm possible fraud or abuse. MDCH on-site visit added Fraud & Abuse Policy March 2008. Accountability is slowly improving with transition of VMBIP to centralized ordering & distribution. Enhanced MCIR to require inventory & reconcile for any lost, wasted or borrowed vaccines (through the VIM). Plan to revise & issue updated Michigan's VFC Resource Book for Providers annually, 2008 to be issued Sept. 30, 2008, at fall IAP meetings. Update VFC Site Visit Questionnaire & guidance annually, will present this at fall IAP as well. NOTE: The CDC Fraud and Abuse policy algorithm is not feasible for this state. It is not perceived to be user-friendly by staff at both state and local levels.

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2.2 By ~~March~~ SEPT 2009, at least 75% of enrolled public & private VFC providers that received a VFC site visit in 2008 will have responded to all high priority storage & handling questions & provided all necessary follow up documentation to the VFC Site Visit questionnaire.	Partially Met – Revised (timeline doesn't match)	Site visits are being conducted, all data is being entered & updated. Maintaining required follow-up documentation, data to be tracked & analyzed. As of July 25, 2008, we have received 49% of the corrective action follow-up.(target is 75%, due by Sept. 30, 2008, which we feel we will achieve) Referrals to AFIX, MCIR & INE as of July 25, 2008: 6 AFIX, 167 MCIR & 180 to INEs. Notification to LHDs or Field Reps of missing or incorrect documentation & track when received. All VFC providers are currently required to enroll and utilize MCIR for vaccine inventory & reporting. Delay of electronic ordering via MCIR had created a barrier & required the use of a paper back-up system. Providers are transitioning to MCIR VIM & begin to start vaccine ordering based on the TOF system. Michigan asked CDC & McKesson for packages of 5 of all vaccines, were granted the option of vaccine that is packaged in a quantity of 5, we could order just 5. Also asked for DT & Td in a minimum of 1 dose, & permission was granted. MCIR VIM & e-ordering trainings will continue as providers transition & MCIR begins e-ordering.
2.3 By December 31, 2012, increase number of VFC site visits conducted to both public & private VFC enrolled providers to at least 50% annually.	Partially Met	Maintain VFC database of site visits conducted. Enhanced VFC data collection by use of MCIR for VFC active status & getting provider information updated. Educate LHDs at fall IAP 2008 of site visit requirements, updated guidance. Targeted provider sites were reviewed & given top priority. Unable to enroll in VFC via MCIR, or track VFC site visits, planned as an enhancement, unknown target date. Currently as of July 25, 2008, LHDs have conducted 1,551 site visits which is 71%. This exceeds the target of 50%.

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2.4 By December 31, 2008, all VFC providers will be enrolled via MCIR & utilize MCIR to ensure proper use of VFC vaccine through tracking measures, follow up & education as developed for all VFC providers.	Partially Met	Began to use MCIR & Vaccine Inventory Module (VIM) in May 2008. All VFC providers must enroll & participate in MCIR VIM. Currently transitioning LHDs with 97 LHD sites (not including LHD depots) & we have 206 private provider sites trained. Nearly all LHDs currently on the new MCIR VIM & several providers. New VIM tracks vaccine wastage, losses & borrowing, as well as alerts LHDs & providers of impending expiration in 6 & 3 months. The state vaccine depot inventory has been nearly depleted. McKesson is the primary shipper to LHDs & VFC providers. Education on centralized distribution & cold chain requirements were provided at IAP meetings & weekly LHD conference calls with MDCH. Continue to track vaccine losses & reimbursements for expired or wasted doses. Vaccine wastage to date is at .01%. Michigan had 6,023 doses lost so far due to expiration. Of those 6,023 doses, 3,023 doses were flu vaccine doses. The cost of the 3,023 flu vaccine doses that expired was $38,482.79. VFC Resource Book for Providers (Michigan) updated annually & will be posted on the MDCH VFC website by Dec. 2008.
2.4a By December 31, 2012, program will be fully integrated with centralized vaccine distribution & ordering via MCIR.	Partially Met	Began to use MCIR & VIM in May 2008. MCIR e-ordering has been delayed. Currently using paper back-up ordering system. Orders are being shipped by McKesson. A tracking system is in place for issues with McKesson.
2.5 By December 31, 2012, MDCH Immunization Program will develop a method to ensure appropriate apportionment of VFC vaccine purchases based on VFC-eligible population.	Partially Met	Submitted annual PES & VOFA to CDC. Utilized PES data to ensure proper apportionment of VFC vaccine purchased. PES data that was pre-populated by CDC was questioned by MDCH & collaborated with CDC & MI Medicaid on the Medicaid numbers. VOFA was based on $12.6 million in 317 funds, however decreased by CDC to $8.3 in March 2008. Eligibility fields are now forced in MCIR, which will lead to better provider accuracy on VFC data entered.

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2.5a By December 31, 2008, program will identify & resolve discrepancies between VFC ordering patterns & most current provider profile for all VFC enrolled providers	Partially Met	Beginning May 2008, all VFC providers were required to participate in MCIR & use the new VIM. Providers & LHDs are being transferred & will continue until all are participating. All provider enrollment data is entered into VACMAN. Eligibility for VFC vaccines is a forced data entry field in MCIR & this will enhance our data in MCIR. Reporting from MCIR (Doses Administered, Ending Inventory) is also required with provider vaccine orders. LHDs review provider orders, & MDCH reviews LHDs orders to identify discrepancies with ordering patterns & provider profiles. Nearly all LHDs currently on the new MCIR VIM & several providers. New VIM tracks vaccine wastage, losses & bor-rowing, as well as alerts LHDs & providers of impending expiration in 6 & 3 months. Continue to track vaccine losses & reimbursements for expired or wasted doses. Vaccine wastage to date is at .01%. Michigan had 6,023 doses lost so far due to expiration. Of those, 3,023 doses were flu vaccine doses. The cost of the expired flu vaccine was $38,482.79. VFC Resource Book updated annually & will be posted on the MDCH VFC website by Dec. 2008.
2.6 By December 31, 2008, implement e-ordering via MCIR, utilizing centralized distribution system.	Unmet	E-ordering is not yet available; plan to implement fall of 2008.. Michigan converted to centralized ordering & distribution May 2008. The state is using a tiered educational roll out plan for VFC providers.
2.7 For five years, estimate 317 & VFC vaccine needs, based on ACIP recommendations, popu-lations to be served, anticipated vaccine uptake & wastage rates, & existing vaccine inventories.	Partially Met (Terri) , Bob	PES & VOFA are completed annually. Maintaining current Adult Immunization Program, including High-Risk Hepatitis A & B. Continue to have a “no tiered” system, all VFC vaccines provided for under-insured kids at provider offices. Wastage is less than 2% for the state. Utilized additional 317 funds to offer HPV4 & Zoster to underserved adults. Enrolling OB/GYN providers to VFC. Targeting adolescent populations by offering first Adolescent Immunization Conference June 2008. Continue to purchase & utilize state supported vaccines.

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Grantee: Michigan Program Component: Immunization Information Systems (IIS)

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
3.1 Through the Sentinel Site project, Immunization lot # & manufacturer fields will be 90% complete for children aged <1 yr in the MCIR.	Partially Met	6/30/2007: children aged <1y: Mfr.: 31.5% Lot: 24.5% 6/30/2008: children aged <1y: Mfr.: 46.3% Lot: 39.3% Completeness of these fields should increase markedly when the VIM is implemented.
3.2 By December 31, 2008, assess the differences between MCIR & NIS coverage estimates using data from the NIS-registry study.	Partially Met (On schedule)	2006Q3: MCIR sentinel area data are lower than NIS, but overlap NIS confidence intervals for 6/11 measures. NIS-registry study interviewing is done, but checking of IIS immunization records remains.
3.3 By December 2012, improve MCIR coverage estimates in the sentinel area to 85% for 4:3:1:3:3:1 series in ages 19-35 mos.	Partially Met	2007Q2: 75.9% 2008Q1: 76.2% The sentinel area will eventually cover the entire state once Wayne, Oakland & Detroit are added. These will likely decreases sentinel area cover-age measures. Coverage with DTaP4 remains a key obstacle.
3.4 Maintain & promote the use of the Influenza Vaccine Exchange Network (IVEN) to facilitate redistribution of non-VFC influenza vaccine, should shortages or maldistribution occur.	Met	IVEN was available for provider use throughout the 2007-2008 influenza season. It was promoted on the MDCH influenza web page & in FluBytes, a weekly influenza update for immunization partners, throughout the influenza season. All IVEN postings were cleared after the June 30, 2008m expiration. At that time, over 10,000 doses were available for redistribution from both private providers & public health clinics.
3.5 Increase adult immunization provider participation levels in MCIR to 70% by 2010.	Unmet	Jan. 1 – July 23, 2008: 1,224 sites reported at least 1 immunization on a person over 20 yrs old. It is not currently possible to determine the adult immunization provider participation levels due to lack of information about providers who aren't yet in the MCIR.

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3.6 Design & develop a Hepatitis B case management module in MCIR	Partially Met	MCIR is in the process of finalizing the *sickle cell* component of case management. Once this component is complete, the development of the *Perinatal Hepatitis B* case management will commence. This project is scheduled for Fall 2008. The Special 317 Adult Hepatitis A & B Initiative Program was established to increase the availability of hepatitis B vaccination to high-risk adults in various venues, including STD/HIV prevention & treatment clinics, & drug treatment programs. Special section 317 funded vaccine were earmarked to purchase hepatitis A & B vaccine for adults seen in Local Health Departments (LHDs), STD clinics, Family Planning clinics, Substance Abuse treatment centers, Methadone treatment centers, HIV medical care clinics & Detroit recovery treatment centers. There were 23,000 doses of Twinrix, the combination hepatitis A & B vaccine, purchased. Based on the latest report for the first two quarters, there were 4 STD clinics; 1 jail; 5 primary care providers; 3 HIV care & treatment centers; 4 Substance Abuse treatment centers; 27 LHDs; & 6 Other facilities enrolled. As of this report, approximately 3,000 doses of vaccine were ordered & dispersed. The HBIG field has been added to our state electronic birth certificate (EBC) record. At this time and due to other vital records issues, this information is not automatically loaded into the MCIR data. The perinatal hepatitis B program staff will continue to manually add this data to the MCIR until these issues are resolved.
3.7 By December 2010, enroll & train 90% of licensed long term care facilities to use MCIR to track all adult immunizations on their patients.	Partially Met	Staff have not been able to devote time due to new release of VIM. Currently there are approximately 25 Nursing homes: R1 0, R2 15, R3 3, R4 4, R5 2, R6 1. Aug. 2007: 4 LTCFs registered in MCIR. June 2008: 8 LTCFs registered in MCIR. Profile reports still need to be expanded to include adult pneumococcal vaccine coverage.

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3.8 Through December 2010, enhance MCIR for tracking vaccines given for occupational health reasons.	Partially Met	Activities: Add TB results to MCIR; Add assessment algorithm for Lab workers in MCIR; Add Health Care Worker notification box in MCIR. Evaluation: Monitor the development & project timelines according to the occupational health project plan.
3.9 Through December 2010, continue to enhance MCIR to meet Public Health Information Network (PHIN) requirements.	(via Gerry B) Partially Met	MCIR Technical Staff attend quarterly PHIN meetings. MCIR Technical staff (1) completed Rhapsody training in June 2008.
3.10 By December 2010, enhance MCIR to send & retrieve HL7 messages.	(via Gerry B) Not Met	Work on this has not started; delayed pending completion of VIM.

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Grantee: Michigan Program Component: Provider Quality Assurance

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
4.1 By December 31, 2008, a minimum of 25% of enrolled VFC providers in the state received an AFIX site visit.	Met	As of June 2008, nearly 75% of our VFC providers have received an AFIX visit
4.2 By December 31, 2008, use CoCASA to track the combined efforts of the AFIX, VFC & INE programs.	Met	CoCASA is used to track VFC, AFIX, & INE contacts & visits.
4.3 By December 2008, demonstrate achievement of Level 1 AFIX Standards.	Met	AFIX Level 1 Standard has been met.
4.4 By December 2012, demonstrate achievement towards meeting Levels 2 & 3 of the AFIX Standards	Met	We continue to work toward the AFIX Level 2 & Level 3 Standards.
4.5 By December 2010, implement use of registry based AFIX reports by private providers.	Ongoing	AFIX reports are functional in the registry, used only by county & state Immunization staff. Plans are being made to meet this objective by December 2010.
4.6 Evaluate registry-based assessment with AFIX visits conducted at the same time as VFC site visits.	Ongoing	AFIX evaluation is currently being conducted.

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Grantee: Michigan Program Component: Perinatal Hepatitis B Prevention

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives

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5.1 Educate and update physicians, hospitals, laboratories and local health departments on Perinatal Hepatitis B Prevention Program (PHBPP) related laws and recommendations.	Met and on-going	In February 2007, the PHBPP created a program manual by specialty area. In March of 2007, the manual was available online, and was revised and updated in June of 2008. A report for January 1, 2008 through June 6, 2008 showed the following specialty areas who viewed this manual: Lab – 315; OB/GYN – 1,486; Hospital – 1,077; Local Health Department – 12,565; Family Practice – 771; Pediatrics – 1,053 with a total of 17,267 hits. We will update the manual annually and will continue to track the number of times it is reviewed. In 2008, seven hepatitis educational presentations were conducted to various health care professionals. In addition to these presentations, the program coordinator presented the Perinatal Hepatitis B Prevention Program (PHBPP) to infection control nurses attending the Michigan Society of Infection Control (MSIC) conference. The coordinator also presented for the Centers for Disease Control and Prevention (CDC) during the Essentials of Perinatal Hepatitis B, "Working With Delivery Hospitals to Prevent Perinatal Hepatitis B Infection, Including the Universal Birth Dose of Hepatitis B Vaccine" in a web cast for perinatal hepatitis B coordinators and case managers. The coordinator and manager provided program updates at the semi-annual Immunization Action Plan (IAP) meeting. Also, the program staff operated an educational booth at seven Immunization Conferences (regional) to provide PHBPP information to the 1700 attendees. In addition to the presentations, educational materials were dispersed to 77 OB/GYN offices and one hospital. These letters reminded the providers to test all pregnant women and to report all pregnant HBsAg positive women to the local health department and/or the state perinatal hepatitis B program as recommended by CDC and required by state law. An OB/GYN chart review abstraction form was created and piloted in two OB/GYN offices. The abstraction form has since been modified and additional chart reviews are being scheduled. A lab survey is currently in draft format. Once final, a mailing will occur to all laboratories identified in Michigan. These surveys will verify hepatitis tests performed and if pregnancy status is confirmed on all women of childbearing years. A reporting process will also be defined and implemented to verify that all HBsAg positive results for women of childbearing years

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5.2 Increase hepatitis B birth dose rates by 5% in 5 years.	Met - on-going	In 2008, of 91 birthing hospitals identified and contacted, 88 of the 91 hospitals, (97%), are enrolled in the Vaccines for Children (VFC) Universal Hepatitis B Vaccination Program. Through this program free hepatitis B vaccine is available for all babies born in these facilities. However, the three hospitals not enrolled have 96%, 93% and 91% hepatitis B birth dose coverage levels. Provider enrollment forms and educational materials have been forwarded to these hospitals. All three facilities have written policies and standing orders to give hepatitis B immune globulin (HBIG) and hepatitis B vaccine to all newborns of HBsAg positive women, to review the pregnant woman's HBsAg status at admission and to record mom's HBsAg status in the baby's chart. At this time, issues have been identified with vital records reporting of the birth dose making staff unable to produce accurate reports to identify birth dose coverage levels by hospital. However, MDCH continues to encourage the birth dose of hepatitis B vaccine and will continue to monitor these levels. Once corrected, MDCH will be able to generate reports and publish articles recognizing high achieving birthing hospitals.

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5.3 Monitor policy and practice pertaining to perinatal hepatitis B prevention at each birthing hospital in the state.	Met - on-going	Hospital surveys were conducted by telephone in the end of 2007 with 100% compliance. These surveys identified key personnel in the delivery hospitals and identified if these hospitals had written policies and standing orders for testing women for hepatitis B, syphilis, HIV and rubella, to provide appropriate documentation and to provide appropriate prophylaxis when indicated. The survey data continues to be updated, but another hospital survey will be conducted during this grant cycle. Based on our latest hospital survey, written policies and standing orders are as follows: 95% of our birthing hospitals provide the birth dose of hepatitis B vaccine prior to hospital discharge; 52% offer hepatitis B vaccine to those less than 2000 grams, the lower numbers are due to hospitals transferring the babies immediately to another facility for care; 87% offer hepatitis B vaccine before hospital discharge to infants born to women with unknown HBsAg status; 96% offer hepatitis B vaccine and HBIG within 12 hours to infants born to HBsAg positive women. (Three said they did not have policies because they have never had a woman deliver who was HBsAg positive. The fourth hospital did not know.) Program staff discussed the importance of the birth dose, the perinatal hepatitis B prevention program, and shared Guidelines for Standing Orders in Labor & Delivery and Nursery Units to Prevent Hepatitis B Virus Transmission to Newborns along with additional educational materials. Hospital chart reviews are now being scheduled. The number of charts in the review at each site is based on a formula defined by CDC. This formula looks at the birth cohort, the percentage of women tested for hepatitis B and the percentage of babies who are documented as receiving the hepatitis B birth dose at birth to determine the number of charts to review. We review mother/baby paired charts to verify documentation of appropriate test information for hepatitis B, syphilis, HIV and rubella, proper documentation of medical record information and appropriate documentation of prophylaxis if needed. A database has been created to record all chart review abstraction information. This data is compared to the hospital surveys to determine areas of excellence and areas in need of improvement. We have conducted three percent of our hospital chart reviews to

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5.4 Increase identification of infants born to HBsAg positive women.	Met	Staff has reviewed several different reporting systems to increase the number of pregnant HBsAg positive women identified in the program. Through the electronic communicable disease reporting, the Michigan Disease Surveillance System (MDSS), 24 pregnant HBsAg positive women were identified (out of 595 reported cases) who were not reported by normal reporting process. Two staff review all records of women of childbearing years (those 10 year of age through 60 years of age) to determine pregnancy. Five infants born to women previously enrolled in the program were identified through a review of MCIR. These women and their infants were not identified through the normal reporting process. Michigan newborn screening (NBS) cards are marked with the mother's HBsAg status for every birth occurring in Michigan. In 2008, 118 NBS cards were received that were marked as mom being HBsAg (+) positive. After review, 73 or 62% were confirmed as being HBsAg positive, the others were incorrectly marked. Out of the 73 that were identified, 8 would otherwise have not have been identified and reported. Additional efforts for identification will be enhanced through a lab survey and review process. A new perinatal hepatitis B data analyst has just been hired to assess this method of reporting.
5.5 Increase completion rates, by 5% over the next 5 years, for the hepatitis B vaccination series and relevant pre/post-vaccination serology in identified case infants and contacts.	Met – on-going	Data for 2006 was reported to CDC in April of 2008. This data revealed the following: 307 infants were identified as being born to HBsAg positive women. Out of the 307 infants, 98% received both HBIG and hepatitis B vaccine within 1 calendar day of birth; 85% received HBIG and a complete hepatitis B series by 8 months of age; 92% received HBIG and a complete hepatitis B series by 12 months of age (this was an increase of 3% from the previous year); 82% received post-vaccination serology (this was an increase of 9% from the previous year).

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Grantee: Michigan Program Component: Adolescent Immunization

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
6.1 By December 2012, provide ACIP-recommended vaccines to VFC-eligible adolescents.	Met	The VFC program follows ACIP recommendations & VFC resolutions as soon as funding is provided to add new vaccines or additional doses. Michigan also supports VFC with 317 funding to assure all adolescent vaccines are provided to all who are eligible, including underinsured in all VFC provider offices. Michigan VFC adopted comprehensive policy that all recommended vaccines must be offered & provided by providers who enroll in VFC; this includes adolescent providers who may just want one type of vaccine, ie OB/GYN
6.1a By December 2008, promote public awareness of newly recommended vaccines for adolescents & the importance of the adolescent health care visit at 11-12 yrs of age.	Partially Met	Maintain updated adolescent brochure outlining vaccines for teens: Met – the pre-teen & teen brochure was recently updated & printed. Post updated educational flyer prominently on Division of Immunization website: Met – (same handout was placed in school packets;) Annually update educational flyer included in school packets: Met; Promote a comprehensive adolescent immunization message: Met - Adolescent Conference on June 5, 2008; AIM Adolescent Educational dinners. Ensure steps in follow-up of MACI recommendation for the addition of MCV4 & Tdap to the 6th grade assessment;

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6.1b By December 2012, promote knowledge and awareness among health care providers regarding adolescent immunization issues.	Met	Maintain comprehensive adolescent immunization education programs in both the office based and physician peer education programs - met. Include comprehensive adolescent information in other professional education program on current vaccine recommendations, strategies to reach adolescent populations, Contraindications and precautions associated with vaccine administration and the appropriate use of VIS - met; Maintain the adolescent immunization section in the AIM Provider Tool Kit - met; Current, comprehensive adolescent immunization information offered at regional conferences – met; also covered at June 5 Adolescent Immunization Conference; Maintain relationship developed with other professional groups which may offer immunization e.g. pharmacists – partially met and continues to grow; Maintain adolescent medicine representative included on MACI; Promote a comprehensive adolescent immunization message to partners – met; always promote a comprehensive message

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6.1c Promote knowledge & awareness among health care providers regarding adolescent immunization issues.	Partially Met	MDCH reaches out to immunization providers a number of ways. Currently there are 2 education programs targeted toward physicians & other medical staff. The Physician Peer Education Project on Immunization (PPEPI) has presented 24 immunization educational programs containing adolescent immunization information to 853 participants. This includes physicians, residents, physician assistants & medical students. These numbers include 5 special adolescent immunization-specific educational dinners that were sponsored, in partnership, by MDCH, PPEPI & the Alliance for Immunization in Michigan (AIM) Coalition. The Immunization Nurse Education Program (INE) targets immunization programs for physicians & their office staff. From January thru June 2008, 93 immunization educational programs on adolescents were presented to 811 medical staff. MDCH also partners with the AIM Coalition to provide immunization educational materials for physicians & their staff both in paper & web formats for adolescent providers. For the reporting period 4,900 paper kits were distributed & there were 770 hits to the adolescent landing page of the online AIM provider tool kit. In addition, VISs for adolescent vaccines are included on both the MDCH & AIM websites, During the reporting period the VIS informational page was viewed 17,107 times. Five articles on adolescent immunization issues were published in a variety of professional organization newsletters & correspondence.
6.2 Enroll new VFC program providers who serve the adolescent population.	Met This will be revised/removed for 2009	Michigan currently has 64 Teen Health Centers/School-Based Clinics enrolled. Created new sector in VACMAN this year for adolescent population non-Teen Health Centers/School-Based Clinics for those providers who newly enrolled with only adolescent populations listed on their provider profiles. Currently there are 4 enrolled under this sector.

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6.2a By December 2012, train new VFC providers & staff regarding procedures for vaccine inventory control, ordering adequate supplies, vaccine storage & handling, administration techniques, documentation, participation in MCIR, & other related issues.	Partially Met/ Ongoing	MDCH promotes a comprehensive vaccine strategy requiring adolescent immunization providers to offer all the recommended adolescent vaccines. Currently the Michigan VFC Program requires all new VFC providers to have an enrollment site visit & education about appropriate storage & handling of vaccines as well as administration & documentation. Referrals are made to MCIR, INE, & AFIX as needed for additional training. For the reporting period of January – June 2008, the INE program conducted: 42 VFC (117 participants), 37 Vaccine Management: Storage & Handling (193 participants), & 16 Vaccine Administration (127 participants).
6.3 By December 2008, Identify juvenile correctional facilities &/or social services agencies serving adolescent populations.	Partially Met	Michigan has identified 570 facilities in the state, per the Dept. of Human Services. Six of these facilities already administer, count & report immunizations. New question added to IAP report that requests LHDs to identify all settings where adolescent vaccinations are provided in their jurisdiction. This includes juvenile detention facilities, STD clinics, etc.

Grantee Name: Michigan Program Component: Adult Immunization

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
7.1 Work with partners (e.g., Quality Improvement Organizations, (QIO) medical professional societies, hospital infection control nurses).	Partially met/Ongoing	AIM Toolkit Adult Folder Now online: www.aimtoolkit.org – 773 hit to the main landing page of the adult section for the months of Jan- June. 4,900 kits have been distributed so far this year. - met; Flu Fighter Action Kit promoted the above evidence-based approaches; targeted towards infection control, occupational health, birthing hospitals, nurses, doctors, etc. INE and Peer Education programs piloted some evidence-based approaches in the modules. Through the MARR coalition, 450 binders were produced with a chapter on immunizations (including standing order templates, schedules, VISs, promotional flyers and brochures geared for this population) and delivered to LTC facilities. An additional 250 binders are currently being assembled.

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
7.2 Obtain feedback from providers, hospitals, & health care personnel (HCP) on developing a tool to measure HCP vaccination rates.	Not Met	Consider measurement for HCP vaccination rates without "double-counting" healthcare facilities in MCIR (HCP flag; separate rosters by provider ID: Give occupational health a separate ID; # new hospitals, provider offices, and healthcare facilities listed in MCIR HCP section); Use of programmer's time in developing VIM/COD and MCIR staff time for said project has created a barrier to utilizing MCIR for this flu season reporting of HCP flu vaccination rates. Barriers: Some progress has been made; meetings have been held to discuss the implementation of this tool; MDCH to meet with MCIR staff in the near future; a Five Year Stepwise plan has been created to reach this anticipated goal Take a multi-agency approach; look at numerous medical organizations & agencies & determine specific & individualized issues for each agency; FEW group continues to evaluate plan on development of this tool. (See 7.1 and data on HP 2010)
7.3 Craft partnership building events in which key immunization players involved in vaccination clinics throughout the state can meet together	Met	60 attendees at June 2007 Community Vaccinator's Forum; Great Evaluations; Continued partnership with conference attendees through FAB and various immunization meetings 1,645 people at 2007 fall regional conferences; Travel Immunizations Conference 2007; Adolescent Conference June 2008 inclusive of Adult recommendations for adolescents 19 years and older; 8 regional conferences scheduled for Fall 2008

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
7.4 Work with partners to increase influenza vaccination of healthcare workers: Create toolkit aimed at improving healthcare personnel (HCP) influenza vaccination rates (and all recommended immunizations) at hospitals & healthcare facilities	Partially Met	Created Flu Fighter Action Kit (FFK) for HCP: over 4,400 hard copy kits were distributed to occupational health, LTC facilities, birthing hospitals, infection control contacts in hospitals, local health depts., and health systems; made available online in early 2008 at www.michigan.gov/flufighterkit HCP vaccination information listed on AIM website at www.aimtoolkit.org See 7.1 HCP vaccination information in FluBytes educational newsletter - Over 1,000 health care professionals receive FluBytes on a weekly basis during the flu season and a bi-weekly and monthly basis in the off-season HCP vaccination information via slide and handout added to INE modules: Adult, OB/Gyn, Infant and Early Childhood, Older Child and Adolescent, Vaccines across the Lifespan. Information included in Peer Ed folders. Information presented at Quarterly MACI & FAB meetings; approximately 100 FAB members; 80 MACI members; meeting minutes of past discussions Regular contributor to 17 partner organization publications Approximately 2,000 posters on HCP vaccination distributed at MDCH conferences and meetings; message promoted in keynote/handout at MDCH Immunization Regional Conferences
7.5 By December 2010, develop and implement and award program to recognize healthcare private provider practices, hospitals, & all other healthcare facilities for Standards of Excellence in patient care with regard to flu vaccination.	Not Met	Barriers: Little progress has been made; meetings have been held to discuss the implementation of this tool; a Five Year Stepwise plan has been created to reach this anticipated goal See objective 7.2; Continue with coordination thru FEW (Flu Education Workgroup) and FAB (Flu Advisory Board)
7.6 Work with partners to increase influenza vaccination of healthcare workers	Partially Met	AIM Toolkit Adult Folder Now online: www.aimtoolkit.org – 773 hit to the main landing page of the adult section for the months of Jan- June. 4,900 kits have been distributed so far this year. AIM Toolkit was displayed/promoted at NIC via business card with web address along with MDCH site.

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
7.7 As 317 funds permits, increase access to vaccines for high risk adults.	Met/Ongoing	Special 317 grant funding for HepA/HepB (Twinrix) to be available in the following settings regardless of insurance status or identified risk group: LHDs , STD, Family Planning, and HIV clinics, Substance Abuse and Methadone Treatment Centers, Detroit Prevention-Treatment-Recovery Program Continuation of MI-VRP program as outlined in MI VFC resource book, Sept. 1, 2007.
7.8 Discuss adult platform at immunization meetings & conferences.	Met	Discussed adult platform at the Community Vaccinators Forum (June 2007), travel vaccine workshop (June 2007), routine meetings (MACI, IAP, INE), fall regional conferences, AIM Coalition meetings - met Discussed the importance of vaccinating ALL populations & the need for adults to stay up-to-date on their immunizations - met; Decreased missed opportunities by encouraging community partners to offer ALL routinely recommended adult vaccines at clinics and retail stores –partially met Communicated adult immunization messages through newsletters, such as FluBytes, MI Immunization Update, Local Liaison Report; INE and Peer Ed sessions; articles in state publications; e-mail communication to immunization partners/organizations Adult Immunizations: Are you Protected? Brochure Website – 2,171 page views Brochures - 3,000 were distributed

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Grantee: Michigan Program Component: Education, Information, Training and Partnerships

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.1 Provide immunization orientation for staff that includes the role of CDC and how it relates to grantee's activities and CDC sponsored immunization updates.	Partially Met	Ensure that immunization program staff members receive an orientation that includes how to use the Immunization Program Operations Manual (IPOM) and a review of Michigan's VFC/Immunization Grant. Not Met (PHA) Ensure that new immunization program staff members attend the 4-part series of the Epi satellite broadcast/webcast --Met
8.2 Distribute VIS and CDC's online instructions to ensure proper use of VIS.		VIS are posted on Division's website. During this time period, there were 17,107 views of this web page. Users can link to this URL from the AIM Toolkit and MCIR websites. Information about the VIS (our handout "Important VIS Facts" was distributed at the June 5 Adolescent conference (which had 160 attendees). MPCA Communications Update (weekly) – included information about the new multi-vaccine VIS and other new VIS during this time period VIS are promoted through our newsletters. (For example, the proper use of VIS is promoted and we also promote any new VIS.) So far in 2008, 2 newsletter issues have been distributed; the newsletters are distributed electronically through a large listserv, in addition to being posted on the Division's website. (The listserv currently contains 4,700 email addresses.)

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.3 By December 2012, ensure that comprehensive immunization information is available to people of all ages.	Partially Met	Brochures are periodically reviewed for accuracy and relevance; Met Brochures addressing the immunization needs of all ages are posted on the Division's website and distributed through our clearinghouse; Protect Babies and Toddlers from Serious Diseases brochure - Website - 1,629 page views Paper Brochures – distributed 45,000 (20,000 of these brochures are being distributed via new mothers' kits (at birthing hospitals) Protect Pre-Teens and Teens from Serious Diseases brochure - Website – 971 page views Brochures - 4,000 were distributed Adult Immunizations: Are you Protected? Brochure Website – 2,171 page views Brochures - 3,000 were distributed The Division of Immunization website has been maintained and kept updated, and it is now organized better, in order to make these materials easier to find. (The section where the brochures are located is organized better. The Channing L. Bete presentation kit is periodically updated by the INEs. Barriers to use in communities: Limited state INE staff time, LHD concerns of non-reimbursement and time of community group meetings (after work hours) Unmet Educate providers on how to communicate with their patient materials: On the web and on AIM TK website; Dr. Dempsey spoke about communicating with parents and adolescents at June 5 Adolescent Immunization Conference; Emphasize the importance of testimonials when urging parents to get their children vaccinated – "be a role model". -Partially Met

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.3a Improve quality of communication with consumers & immunization partners.	Partially Met	During 2008, the layout of the Michigan Immunization Update newsletter has been freshened up. We have only published 3 issues so far. (We are planning to publish 1-2 more issues this year. Five of the Division of Immunization brochures have been revised this year. In each of these brochures, about ½ dozen websites etc of reliable sources of information for those consumers who have questions have been added, including contact information for CDC. Articles were submitted to 10 different professional organizations/associations during the first half of 2008. "Create awareness of available educational materials to community vaccinators including pharmacies, corporations, nursing associations, etc." We sent 48 AIM Kits to the Michigan Pharmacists Association to be incorporated in their trainings, when they train pharmacists to administer immunizations. The MSIC (Michigan Society of Infection Control) distributed 165 AIM Kits at their annual spring conference. See INE/Peer Ed numbers, 8. Revised FluBytes in 2007 and continually improve it as needed Partially Met
8.4 By December 31, 2008, ensure that the appropriate staff members receive training in how to effectively reach diverse groups of people, including those with low literacy skills.	Partially Met	2 staff attended health literacy seminar spring 2008; *will present findings and lessons learned at November 2008 staff meeting* Staff attended communication strategies workshops at NIC and in-state.
8.4a Develop and seek feedback on information that is culturally sensitive, relevant, and "owned" by the target audience.	Partially Met	Immunization Division has established an ongoing sub-committee, *Immunization Disparities Workgroup* to lead efforts to decrease the gap related to immunization health disparities. They are currently working with National Arabic Medical Association. Peer Ed presentation done for Michigan Chapter June 2008 in Dearborn.

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.5 Create and maintain a list of contacts at hospitals, health maintenance organizations, health insurance companies, and professional organizations.	Revised (not realistic)	Partially Met – obtained lists for Flu Fighter Kit mailing; updated lists for flu and health care personnel letter to be sent out in July 2008. Perinatal Hep B program has developed a list OB/Gyn providers and birthing hospitals. INE program has begun a list of Nursing Schools with n MI colleges and universities. AIM coalition list serve has been updated/ongoing MACI meetings are available via in-person and teleconference for interested parties; list serve has been updated/ongoing FAB list serve has been updated/ongoing

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.6 Collaborate with other State Agencies and Departments to promote immunizations to their staff and to consumers.	Met	Create and maintain a list of contacts at other State Agencies and Departments; Identify all state agencies that work with or serve high risk populations for routinely recommended vaccines; Working with the Civil Service Commission to coordinator efforts for the state flu campaign; writing monthly wellness newsletters focusing on flu and developing an Intranet module for state employees on flu vaccination and where to go to get vaccinated. Working through the MDCH Wellness Coordinator, collaborate with other State Agencies and Departments to insert vaccine information into their publications or mailings; Met, see above Collaborate with the Department's Chronic Disease Division to promote the flu vaccine to those in their target audience with chronic diseases; Division staff assigned to internal internal hepatitis and HPV work groups to promote the immunization message to the appropriate target audience; Articles are routinely submitted to the Epi Insight publication and the Local Liaison Report; Sent out flu vaccination message to all state employees during the 2007-08 flu season Worked with MI Dept of Transportation to create and disseminate hand hygiene posters/safety talks on influenza; will be distributing to all state agencies for the 2008-09 flu season We also work on a regular basis with the Dept of Labor and Economic Growth, The Office of the State Employer, the Governor's Office, and the MI Occupational Safety and Health Administration
8.8 Maintain updated seasonal, avian, and pandemic influenza web pages.	Met	# hits to MDCH flu website www.michigan.gov/flu - Page views from Nov 2007 to mid-April 2008; >8,000 hits to flu home page; >2,000 hits to seasonal flu page; >1,400 hits to pandemic flu page; updated flu website in June 2008 – will review updates at August 2008 Flu Advisory Board meeting

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.9 Maintain updated Immunization Nurse Education & Physician Peer Education Programs	Met	Maintain relationship developed with other professional groups which may offer immunization e.g. pharmacists Immunization Nurse Education (INE) sessions/participants in 2008: Infant and Early Childhood 44/252 Older Children and Adolescents 32/246 Adult 7/91 Vaccines across the Lifespan 33/349 Vaccine Administration 11/66 VFC Program 24/86 Vaccine Management 30/166 Other (Special Presentations) 10/68 PPEPI sessions/participants in 2008 Family Medicine 10/360 Adult 3/107 Varicella 2/91 Adolescent 5/252 OB 3/76 HCP 1/23 Pediatrics 6/238 Regular contributor to 17 partner organization publications

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
8.10 Communicate regularly on influenza issues with all immunization partners.	Met	Created Flu Fighter Action Kit (FFK) for HCP: over 4,400 hard copy kits were distributed to occupational health, LTC facilities, birthing hospitals, infection control contacts in hospitals, local health depts., and health systems; made available online in early 2007 at www.michigan.gov/flufighterkit HCP vaccination information listed on AIM website at www.aimtoolkit.org – average of 400 unique visitors/month; 42,774 page views and 566,243 website hits in 2007; 6,500 hard copy kits ordered in 2007 HCP vaccination information in FluBytes educational newsletter - Over 1,000 health care professionals receive FluBytes on a weekly basis during the flu season and a bi-weekly and monthly basis in the off-season Information presented at Quarterly MACI & FAB meetings; approximately 100 FAB members; 80 MACI members; meeting minutes of past discussions Regular contributor to 17 partner organization publications Approximately 2,000 posters on HCP vaccination distributed at MDCH conferences and meetings 60 attendees at June 2007 Community Vaccinator's Forum – keep in regular contact with these attendees; 1,645 people at 2007 fall regional conferences
8.10a By December 2010, through influenza education & outreach; change behaviors & facilitate paradigm shift from what is considered "late season" flu vaccination to a belief & buy-in from all immunization partners for an extension of the entire flu season	Partially Met	Complete paradigm shift hasn't occurred, but numerous educational sessions and presentations have been given on this topic Paradigm shift discussed at FAB, MACI, in FluBytes, on the flu website, and at fall regional immunization conferences Flu Partnership survey conducted in 2007; 2008 survey in progress
Consumer Education	Met	See Appendix B

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives

Grantee: _____ Program Component: Epidemiology and Surveillance

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
9.1 Enroll a sufficient number of sentinels to ensure one regularly reporting sentinel per county or one regularly reporting sentinel per 250,000 population in large counties	Not Met	There are *enrolled* sentinel sites in 49 of 83 (59%) counties. Thirty-three (40%) of the 83 counties have at least one *regularly reporting* sentinel site. Seventy-seven counties have less than 250,000 population; of these 27, (35%) have at least one sentinel *regularly reporting* sentinel site. Seven counties have population 250,000 or greater; of these, 2 (29%) have one *regularly reporting* sentinel per 250,000 population.
9.2 By December 2009, increase the proportion of regularly reporting sentinels by 5%.	Met	Between the 40-week period between MMWR weeks 200740 and 200827, we received 20 reports from 52/98 (53%) of enrolled sentinels.
9.3 Increase the proportion of sentinel reports received on time (no later 3 days after the week ending date) by 10%.	Not Met	Between MMWR weeks 200740 and 200828, 862/1881 (46%) of reports arrived 3 or less days after the week ending date; 66% arrived 7 days or less after the week ending date. A barrier to meeting this objective was that the influenza sentinel coordinator was absent during most of the flu season and unable to send weekly reminders.
9.4 By December 31,2008, revise and promulgate Michigan-specific investigation guidelines for VPDs.	Met	Posted to MDCH Immunization web-site at www.michigan.gov/immunize

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
9.5 Maintain VPD surveillance systems in place, with emphases on further development of NEDSS-compliant reporting, incorporating registry data, and data analyses.	Met	VPD Occurrence data, 1st half of 2008, Michigan (provisional data, subject to change): Chickenpox: 1734 Diphtheria: 0 H. influenzae invasive (all ages, all serotypes) 12 1 type b in infant Measles 4 Mumps:19 Pertussis 85 Polio : 0 Rubella :1 Tetanus :1 Hep. A: 76 Hep. B: 82
9.6 By December 31/2008, implement and promote varicella case-based reporting.	Met	Michigan continues to be a leader in providing varicella surveillance data; case-based reporting & surveillance has been implemented. Data year-to-date (Jan. – June 2008) indicates about a 40% decline in cases compared to the same period of 2007; this was reviewed for any possible role of surveillance artifact but none has been identified, and we conclude that the lower levels being reported this year would appear to reflect an actual decline in incidence.
9.7 Institute varicella outbreak tracking.	Met	We are working with our Local public health partners to track varicella outbreaks and have them reported to the state with basic outbreak information. For 2007, for the first time, we submitted the Varicella Outbreak Reporting Worksheet to CDC.
9.8 By December 2010, review the possibility of implementing a state recommendation for records checks and exclusion of susceptibles in varicella outbreaks involving group activity settings (schools, day care centers, etc).	Partially Met	This has been implemented in some jurisdictions.

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
9.9 Monitor surveillance quality.	Partially Met	Chart available upon request
9.10 Review of VAERS reporting flow, i.e. determine if traditional distinct private/public reporting pathways should be maintained or consolidated to single path emphasizing electronic web-based VAERS reporting.	Partially Met	In the revised VAERS guidance, we have allowed for VAERS reports related to public-sector vaccine administration to be submitted either to MDCH by paper or directly to national VAERS office via web-based report
9.11 Provide feedback of VPD surveillance to partners and public health and provider communities.	Met	Summary of VPD 2007 promulgated.

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Grantee: Michigan Program Component: Populations Assessment

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
10.1 Assess all Kindergartners, new entrants to a school district, & 6th grade students in public & private schools in November & February of each year.	Partially Met	100% schools reported via the MCIR. Barrier – 2 school districts out of 525 school districts in state lost 5% of their state-aid funding due to unability to meet the compliance rate as mandated.
10.2 By December 31, 2008, assess all children enrolled in licensed child care centers for annual assessment.	Met	100% of licensed child care centers reported via the MCIR.
10.3 By December 2008, monitor areas with unvaccinated students or waivers.	Not Met	2006-2007 o 93% of schools complete; 4% of students waivered o 87% of childcares complete; 2% of children waivered • 2007-2008 o 95% of schools complete; 3% of students waivered o 84% of childcares complete; 3% of children waivered • Year-end 2007: 3940 childcares in MCIR. Year-to-date 2008: 3871 childcares in MCIR (will increase further in fall 2008) Development of an online MCIR mapping application is planned, but is sidelined because geocoding is not happening regularly. This should happen once the VIM is completed. A manuscript describing immunization waiver trends in Michigan by waiver type & immunization type is in progress. Maps & Excel workbooks that display immunization coverage information by school district, school building, & zip code have been produced & made available to LHDs.
10.4 By December 31, 2012, strengthen the adolescent school requirements through administrative processes.	Bob	

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Grantee: Michigan Program Component: WIC Linkage

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives
11.1 Through 2012, maintain quarterly Immunization Workgroup Meetings with WIC & Medicaid.	Met	Quarterly meetings occur and are regularly attended by each division, including PIO.
11.2 By December 31, 2008, increase the WIC coverage level in MCIR by 5% for the 4:3:1:3:3:1 series.	Not Met	Coverage is 72% (54,398 up to date; n= 75,717). Due to HIB shortage. Expansion of WIC program due to high unemployment rates.

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Grantee: Michigan Program Component: IIS Sentinel *Sites (only for the 8 grantees awarded supplemental funds for this project)*

Objective	Status of Objective	Description of Barriers and Successes to Meeting Objectives

Grantee: _____ Program Component: Enhanced Perinatal Hepatitis B Prevention

1) By March 31, 2008, identify and incorporate core data elements to enhance case management.	Met and on-going	Michigan was awarded an Enhanced Perinatal Hepatitis B Prevention Program (EPHBPP) grant in March 2008. CDC met with the previously awarded grantees and developed core data elements. These core data elements were included in the reporting documents, the Hepatitis B Perinatal Case Report Form (CRF) – Infant/Contact (used by providers and hospitals) and the Perinatal Hepatitis B Intake Form (used by our local health departments). MDCH developed a database for the submission of these new core data elements. Eighty-three local health departments (LHD) and ninety-one birthing hospitals in our state were notified and provided the updated forms. This information was shared throughout the state at the semi-annual Immunization Action Plan (IAP) meetings, in the Immunization Update Newsletter, the Epidemiology Information newsletter, and through the Michigan State Medical Society (MSMS) newsletter. As providers are contacted requesting additional vaccination information, updated CRFs are provided. A preliminary report has been submitted to CDC for 04/01/08 through 06/30/08. There were 64 cases identified and enrolled in the EPHBPP. The additional core data elements take additional time to obtain, document and record. The activities for this objective will be revised to better measure the success of this project.

2) By December 31, 2009, increase identification of infants born to HBsAg-positive women by targeting five SE Michigan counties that are under-reporting based on CDC point estimates.	On-going	The new EPHBPP data analyst is scheduled to start August 4, 2008. He will work with the staff to complete the laboratory survey document which is in the draft form. The new analyst will also assist in developing our process to generate and collect reports from individual laboratories. Currently, staffs has collected and compared one hospital lab's information to the communicable disease reporting system (MDSS) and have identified 11 women who were pregnant and hepatitis B surface antigen (HBsAg) positive. From the 11 cases, 3 were not reported properly. We will continue to develop this process for all labs in Michigan. Due to vital records issues with our electronic birth certificate (EBC) records we are unable to monitor or check the EBC to determine if the "infections present and/or treated during this pregnancy " have been completed. Work will continue in this area.
3) By December 31, 2009, enhance awareness and education and strengthen relationships between the Perinatal Hepatitis B Prevention Program (PHBPP) and prenatal care providers.	Met	MDCH has completed two OB/GYN chart reviews and have started scheduling additional reviews. Staff has provided additional educational materials to all 77 survey respondents. Educational programs are being developed.
4. By December 31, 2009, monitor and provide feedback on the Universal Hepatitis B Prevention Program.	Met	The program coordinator continues to provide feedback to our birthing hospitals on their birth dose percentages. Due to a vital records issue, MDCH is unable to provide accurate birth dose coverage level information. Staff will continue to work with hospitals to encourage the administration and documentation of the birth dose of hepatitis B vaccine for all newborns.

Appendix A
Pandemic Influenza Doses Administered Pilot Reporting Event (PIDAPRE)

Background: In the event of an influenza pandemic, timely and complete reporting of Pandemic Influenza vaccine doses administered will allow the federal government and Project Areas to closely monitor the use of the vaccine while it is in scarce supply. CDC and the Project Areas are planning to use a small number of seasonal influenza clinics as proxies for pandemic influenza vaccine administration sites to evaluate technical systems for monitoring pandemic influenza vaccine doses administered. Project Areas will be assessed on their ability to collect and report to CDC on vaccine doses administered and CDC will assess the technical capability of the CRA to transmit and aggregate Project Area data. The goal is to conduct this exercise with minimally invasive impact to normal operations. This pilot will involve submission of a minimal number of data elements to CDC.

Why is the pilot project needed?

- To assess ability to collect and report vaccine doses administered data
- To assess the technical ability of CDC's CRA to transmit and aggregate Project Area data
- To provide perspective on federal, Project Area and clinic needs in order to scale-up for a pandemic situation
- To identify and address system gaps
- Testing tooling options and security aspects for federal and state partners
- Accomplish timely data exchange between key parties
- Initial attempt to exercise vaccine tracking plans

Collaborators:

- CDC –NCPHI, NCIRD, COTPER
- Project Areas: Public Health Emergency Preparedness (PHEP) and Immunization programs' staff
- Selected large, public sector, seasonal influenza clinic site(s)

Project Area Commitments: Data Expected and Frequency:

- Number of Clinics and Frequency: We are interested in getting at least two distinct transmissions of data.
    - If only one clinic site is being used, data from at least two clinic sessions should be reported using two distinct transmissions.
    - If more than one clinic site is being used, data from at least one session for each site should be reported using a distinct transmission for each site.
- Time Frame: Clinic sessions should occur between November 1 and December 31, 2007; data from each clinic should be compiled and transmitted within 48 hours of the clinic session.
- Data: (Variables represent a subset of the data needed for pandemic influenza vaccine doses monitoring and are selected as they are likely to be collected by seasonal influenza clinics as part of routine practice.)
    a. Will NOT include: priority group, dose number
    b. Will include: age (analytically relevant to pan flu and seasonal flu data collection), project id, date of pilot

Expected Benefits or lessons learned:

- Illustrate technical gaps and needs.
- Identify operational barriers
- Understand training needs of staff
- Identify equipment needs and capabilities
- Gain a preliminary understanding of cost and other impact implications to clinical operations
- Provide a framework for developing future pan flu reporting plans

Expected Challenges:

- Communication and support challenges among all parties
- Availability/distribution of seasonal vaccine
- Technical glitches and training and equipment needs
- Clinic scheduling
- Timeliness and completeness of reporting

Appendix B

Consumer Education Information

July 2008

Jacquelyn Jones and Dianne Matelsky received 195 telephone calls for the months of: April, May, and June. This consumer education log is broken down into five categories. The categories are as follows: caller type, organizational type, topic, referrals and comment section.

The caller types consist of several different categories. The categories are as follows: school/childcare, citizen, doctors, governmental workers, hospital and other category. Of the 195 calls 93 school/childcare, 26 citizen, 5 doctor, 10 government workers, 1 hospital, 25 nurses, 33 other, and 2 out of state.

The organizational types consist of several different categories. The categories are as follows: 2 Charter Schools, 39 Child Care, 1 Doctor's Office, 1 Family Health, 7 Government Agency, 3 Hospitals, 31 Local Health Department (LHD), 1 MCIR Help, 1 Michigan Primary Care Association, 1 Michigan Public Health Institute , 4 Migrant, 8 Other, 4 Out of State Calls, 1 Pediatric Office, 2 Pharmacy, 11, Private School, 2 Professional Organizations, 3 Provider Office, 5 Public Schools and 1 Travel Clinic.

The topic types consist of several different categories. The categories are as follows: 13 Attorney General's Follow-up Letters, 1 Childcare Question, 14 Health Appraisals Request, 13 Immunization Record Request, 1 Immunization Question, 9 Information Materials, 1 Inform Consent Question, 47 Michigan Care Improvement Registry (MCIR), 1 Migrant Issue, 19 Other, 3 Request for Immunization Cards, 6 School & Childcare Assessment Question, 3 Specific Disease Questions, 6 Travel Questions, 11 Vaccine Questions, 1 Vaccine For Children Question, 7 Vaccine Information Statements (VIS), 2 Vaccine Preventable Disease Questions and 1Waiver Question.

Out of the 195 calls 28 of these calls were referred to Department of Human Services, Division of Immunization Staff, Local Health Departments, MCIR Help Desk, and MCIR Regions.